FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032789

Facility Name: SHARON HEALTH CARE ELMS, INC.

Address: 3611 N. ROCHELLE (Number) PEORIA (City) 61604 (Zip Code)

County: PEORIA

Telephone Number: (309) 685-4412 **Fax #** (309) 688-4950

IDPA ID Number: 36-3530585

Date of Initial License for Current Owners: 8/15/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) RICHARD SGARLATA, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,234	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	28,488	2,236		30,724	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,488	2,236		30,724	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.79%

D. How many bed-hold days during this year were paid by Public Aid? 112 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/15/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	161,836	21,313	10,755	193,904		193,904		193,904			1
2	Food Purchase		141,098		141,098		141,098	(102)	140,996			2
3	Housekeeping	99,276	15,838		115,114		115,114		115,114			3
4	Laundry	57,987	20,206		78,193		78,193		78,193			4
5	Heat and Other Utilities			78,690	78,690		78,690	690	79,380			5
6	Maintenance	49,921		40,421	90,342		90,342	(22,325)	68,017			6
7	Other (specify):*											7
8	**TOTAL General Services**	369,020	198,455	129,866	697,341		697,341	(21,737)	675,604			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	686,745	50,047	99,961	836,753		836,753		836,753			10
10a	Therapy	50,493		4,106	54,599		54,599		54,599			10a
11	Activities	59,150	3,090	2,220	64,460		64,460		64,460			11
12	Social Services	52,528		8,695	61,223		61,223		61,223			12
13	Nurse Aide Training	1,644	1,448	663	3,755		3,755		3,755			13
14	Program Transportation			2,167	2,167		2,167		2,167			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	850,560	54,585	123,812	1,028,957		1,028,957		1,028,957			16
	C. General Administration											
17	Administrative	96,923			96,923		96,923	137,010	233,933			17
18	Directors Fees											18
19	Professional Services			18,018	18,018		18,018	579	18,597			19
20	Dues, Fees, Subscriptions & Promotions			10,419	10,419		10,419	(912)	9,507			20
21	Clerical & General Office Expenses	89,109	15,947	15,550	120,606		120,606	(6,229)	114,377			21
22	Employee Benefits & Payroll Taxes			195,745	195,745		195,745	(685)	195,060			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,528	1,528		1,528		1,528			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,785	27,785		27,785	44	27,829			26
27	Other (specify):*							5,978	5,978			27
28	**TOTAL General Administration**	186,032	15,947	269,045	471,024		471,024	135,786	606,810			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,405,612	268,987	522,723	2,197,322		2,197,322	114,048	2,311,370			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SHARON HEALTH CARE ELMS, INC.
0032789
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #		
22	EMPLOYEE BENEFITS	
2	FOOD	

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	
19	PROFESSIONAL FEES	

To reclass cost of appealing real estate taxes

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. #0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			19,407	19,407		19,407	75,200	94,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,791	18,791		18,791	83,684	102,475			32
33	Real Estate Taxes			30,449	30,449		30,449	3,284	33,733			33
34	Rent-Facility & Grounds			196,985	196,985		196,985	(190,824)	6,161			34
35	Rent-Equipment & Vehicles			14,354	14,354		14,354		14,354			35
36	Other (specify):*							(18,664)	(18,664)			36
37	**TOTAL Ownership**			279,986	279,986		279,986	(47,320)	232,666			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,540	1	56,541		56,541		56,541			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		56,540	54,353	110,893		110,893		110,893			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,405,612	325,527	857,062	2,588,201		2,588,201	66,729	2,654,930			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,743	30		9
10	Interest and Other Investment Income	(6,724)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(102)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(415)	22		19
20	Contributions	(673)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,669)	21		24
25	Fund Raising, Advertising and Promotional	(93)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,538)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,471)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	89,200		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 89,200		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 66,729		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SHARON HEALTH CARE ELMS, INC.

ID# 0032789

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 6,461	6	1
2	RESIDENT GIFTS	(270)	22	2
3	COPE DUES TO ICLTC	(149)	20	3
4	PAINTING AND DECORATING	(29,580)	6	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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17				17
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(23,538)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(102)											(102)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities						690						690	5
6	Maintenance	(23,119)					794						(22,325)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(23,221)					1,484						(21,737)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				137,010								137,010	17
18	Directors Fees													18
19	Professional Services			185	113	281							579	19
20	Fees, Subscriptions & Promotions	(915)					3						(912)	20
21	Clerical & General Office Expenses	(5,669)					(560)						(6,229)	21
22	Employee Benefits & Payroll Taxes	(685)											(685)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice						44						44	26
27	Other (specify):*				4,984		994						5,978	27
28	**TOTAL General Administration**	(7,269)		185	142,108	281	481						135,786	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,490)		185	142,108	281	1,965						114,048	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	14,743		59,831		626							75,200	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,724)		90,404		4							83,684	32
33	Real Estate Taxes			(556)		1,713	2,127						3,284	33
34	Rent-Facility & Grounds			(180,585)		(2,000)	(8,239)						(190,824)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*					(18,664)							(18,664)	36
37	**TOTAL Ownership**	8,019		(30,906)		(18,321)	(6,112)						(47,320)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(22,471)		(30,721)	142,108	(18,040)	(4,147)						66,729	45

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	PEORIA FOREST PARTNERSHIP	100.00%	$ 185	$ 185	15
16	V	30	DEPRECIATION		PEORIA FOREST PARTNERSHIP		59,831	59,831	16
17	V	32	INTEREST		PEORIA FOREST PARTNERSHIP		90,404	90,404	17
18	V	33	REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		(556)	(556)	18
19	V								19
20	V	34	RENT	180,585	PEORIA FOREST PARTNERSHIP			(180,585)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 180,585			$ 149,864	$ * (30,721)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	REDWOOD MANAGEMENT	100.00%	$ 113	$ 113	15
16	V								16
17	V	17	MANAGEMENT FEES		REDWOOD MANAGEMENT				17
18	V								18
19	V	17	SALARY-L.SHLOFROCK		REDWOOD MANAGEMENT		101,760	101,760	19
20	V	27	PAYROLL TAXES-LS		REDWOOD MANAGEMENT		2,273	2,273	20
21	V								21
22	V	17	SALARY-J.SHLOFROCK		REDWOOD MANAGEMENT		15,000	15,000	22
23	V	27	PAYROLL TAXES-JS		REDWOOD MANAGEMENT		1,154	1,154	23
24	V								24
25	V	17	SALARY-S. ARON		REDWOOD MANAGEMENT		15,000	15,000	25
26	V	27	PAYROLL TAXES-SA		REDWOOD MANAGEMENT		1,154	1,154	26
27	V								27
28	V	17	SALARY-J.MAGIT		REDWOOD MANAGEMENT		5,250	5,250	28
29	V	27	PAYROLL TAXES-JM		REDWOOD MANAGEMENT		404	404	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 142,108	$ * 142,108	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	UNIT SIX PARTNERSHIP	100.00%	$ 281	$ 281	15
16	V	30	DEPRECIATION		UNIT SIX PARTNERSHIP		626	626	16
17	V	32	INTEREST		UNIT SIX PARTNERSHIP		4	4	17
18	V	33	REAL ESTATE TAX		UNIT SIX PARTNERSHIP		1,713	1,713	18
19	V	36	GAIN ON SALE OF ASSET		UNIT SIX PARTNERSHIP		(18,664)	(18,664)	19
20	V								20
21	V	34	RENT	2,000	UNIT SIX PARTNERSHIP			(2,000)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,000			$ (16,040)	$ * (18,040)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BARTON MANAGEMENT INC.	100.00%	$ 690	$ 690	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		794	794	16
17	V	20	DUES, SUBS. & FEES		BARTON MANAGEMENT INC.		3	3	17
18	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		(560)	(560)	18
19	V	26	INSURANCE		BARTON MANAGEMENT INC.		44	44	19
20	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		994	994	20
21	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.		2,127	2,127	21
22	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.		6,161	6,161	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	14,400	BARTON MANAGEMENT INC.			(14,400)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,400			$ 10,253	$ * (4,147)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LEON SHLOFROCK	OWNER	Administrative	21.12%	SEE ATTACHED	4	8.00	Alloc-Rdwd	$ 101,760	17-7	1
2	JOHN SHLOFROCK	OWNER	Administrative	9.57%	SEE ATTACHED	8	17.02	Alloc-Rdwd	15,000	17-7	2
3	JOE MAGIT	OWNER	Administrative	8.55%	SEE ATTACHED	3	8.57	Alloc-Rdwd	5,250	17-7	3
4	STAN ARON	OWNER	Administrative	11.66%	SEE ATTACHED	3.5	5.38	Alloc-Rdwd	15,000	17-7	4
5	GARY WEINTRAUB	OWNER	Legal	2.05%	SEE ATTACHED	5.5	12.50	SALARY	17,707	17-1	5
6	ELISA SHLOFROCK-ZUSM	OWNER	Administrative	2.05%	SEE ATTACHED	5.5	13.75				6
7	JEAN SHLOFROCK	RELATIVE	Secretary		SEE ATTACHED	3	7.50				7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 154,717		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PEORIA FOREST PARTNERSHIP
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 1,100	$	99	$ 185	1
2	30	DEPRECIATION	BED SIZE	590	4	356,566		99	59,831	2
3	32	INTEREST	BED SIZE	590	4	538,773		99	90,404	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	(3,311)		99	(556)	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 893,128	$		$ 149,864	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REDWOOD MANAGEMENT
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 675	$	99	$ 113	1
2										2
3										3
4										4
5	17	SALARY-L.SHLOFROCK	AVG HOURS WORKED	25	5	636,000	636,000	4	101,760	5
6	27	PAYROLL TAXES-LS	AVG HOURS WORKED	25	5	14,206		4	2,273	6
7										7
8	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED	32	4	60,000	60,000	8	15,000	8
9	27	PAYROLL TAXES-JS	AVG HOURS WORKED	32	4	4,615		8	1,154	9
10										10
11	17	SALARY-S. ARON	AVG HOURS WORKED	14	4	60,000	60,000	4	15,000	11
12	27	PAYROLL TAXES-SA	AVG HOURS WORKED	14	4	4,615		4	1,154	12
13										13
14	17	SALARY-J.MAGIT	AVG HOURS WORKED	12	4	21,000	21,000	3	5,250	14
15	27	PAYROLL TAXES-JM	AVG HOURS WORKED	12	4	1,616		3	404	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 802,727	$ 777,000		$ 142,108	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: UNIT SIX PARTNERSHIP
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 1,675	$	99	$ 281	1
2	30	DEPRECIATION	BED SIZE	590	4	3,731		99	626	2
3	32	INTEREST	BED SIZE	590	4	22		99	4	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	10,206		99	1,713	4
5	36	GAIN ON SALE OF ASSET	BED SIZE	590	4	(111,229)		99	(18,664)	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ (16,040)	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BARTON MANAGEMENT INC.
Street Address: 465 CENTRAL AVE.
City / State / Zip Code: NORTHFIELD, IL 60093
Phone Number: (847) 441-8200
Fax Number: (847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	199,800	8	$ 9,569	$	14,400	$ 690	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	199,800	8	11,020		14,400	794	2
3	20	DUES, SUBS. & FEES	RENTAL INCOME	199,800	8	40		14,400	3	3
4	21	CLERICAL AND GENERAL	RENTAL INCOME	199,800	8	(7,772)		14,400	(560)	4
5	26	INSURANCE	RENTAL INCOME	199,800	8	604		14,400	44	5
6	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	199,800	8	13,792		14,400	994	6
7	33	REAL ESTATE TAXES	RENTAL INCOME	199,800	8	29,507		14,400	2,127	7
8	34	RENT OFFICE SPACE	RENTAL INCOME	199,800	8	85,477		14,400	6,161	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 142,237	$		$ 10,253	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	PEORIA FOREST	X		WORKING CAPITAL	N/A	1/1/96	38,014		DEMAND	6.0000	18,791	6
7												7
8												8
9	TOTAL Facility Related						$ 38,014	$			$ 18,791	9
	B. Non-Facility Related*											
10	Supplemental Schedule										83,684	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 83,684	14
15	TOTALS (line 9+line14)						$ 38,014	$			$ 102,475	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (6,724)	1
2	ALLOC-PEORIA FOREST	X									90,404	2
3	ALLOC-UNIT SIX	X									4	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 83,684	21

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	30,922	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	33,516	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,594	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,139	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	33,733	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	28,509	8
	1996	27,536	9
	1997	28,731	10
	1998	30,021	11
	1999	30,232	12

2000 ACCRUAL CALCULAITON = 30232 X 1.03 = 31139

ALLOCATED FROM PEORIA FOREST - (556)

ALLOCATED FROM BARTON - 2127

ALLOCATED FROM UNIT SIX - 1713

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,372 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

SHARON HEALTHCARE WILLOWS - FACILITY - 219 BEDS
SHARON HEALTHCARE WOODS - FACILITY - 152 BEDS
SHARON HEALTHCARE PINES - FACILITY 120 BEDS
PEORIA FOREST - CENTRAL DIETARY (FORMERLY UNIT SIX PARTNERSHIP)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 105,034	1
2	ALLOC - PEORIA FOREST			8,390	2
3	TOTALS			$ 113,424	3

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991		$ 1,865,694	$ 59,236	31.5	$ 59,236	$	$ 575,082	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	5,207	165	20	260	95	2,736	9
10	Various			1988	4,581	169	20	240	71	2,554	10
11	Various			1989	1,877	60	20	94	34	881	11
12	Various			1990	6,666	297	20	373	76	3,570	12
13	Various			1991	23,422	777	20	1,189	412	9,902	13
14	Various			1992	19,136	642	20	974	332	7,381	14
15	Various			1994	9,731	250	20	487	237	3,003	15
16	Various			1995	2,723	69	20	136	67	743	16
17	WATER HEATER			1996	1,952	50	20	98	48	474	17
18	SEWER			1996	1,310	34	20	66	32	291	18
19	CARPET			1996	841	22	20	42	20	175	19
20	ROOFTOP GAS UNIT			1997	5,247	135	20	262	127	830	20
21	ROOF C/WING			1997	4,851	124	20	243	119	790	21
22	ROOF B/WING			1997	2,015	52	20	101	49	328	22
23	SHELVING			1997	590	15	20	30	15	110	23
24											24
25	PAGE 12-1 REP TOTALS				39,432	1,221		595	(626)	595	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				2,959	36		75	39	75	34
35	PAGE 12A TOTALS				55,440	1,087		2,152	1,065	4,785	35
36	TOTAL (lines 4 thru 35)				$ 2,053,674	$ 64,441		$ 66,653	$ 2,212	$ 614,305	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL BATH			1997	6,684	171	20	334	163	1,197	9
10	PHONE SHELF			1998	207	5	20	10	5	26	10
11	ROOFTOP HEAT/COOL			1998	5,147	132	20	257	125	771	11
12	ROOFING			1998	3,187	82	20	159	77	358	12
13	PATIO RAMP			1998	538	14	20	27	13	63	13
14	AMER II MINUTEMAN			1998	272	7	20	14	7	34	14
15	LAWN REPAIR			1998	625	16	20	31	15	83	15
16	DRAPES			1998	5,805	149	20	290	141	604	16
17	WATER SOFTENER			1998	1,700	44	20	85	41	220	17
18	ROOFTOP UNIT			1998	1,472	38	20	74	36	185	18
19	ROOF			1999	996	26	20	50	24	58	19
20	REPLACE DRAIN LINES			1999	1,993	51	20	100	49	108	20
21	CONCRETE PARKING LOT			1999	969	25	20	48	23	56	21
22	WINDOWS			1999	481	12	20	24	12	44	22
23	CUBICLE CURTAINS			1999	2,586	66	20	129	63	237	23
24	CUBICLE TRACKING			1999	3,724	95	20	186	91	341	24
25	GARAGE DOOR			1999	142	4	20	7	3	13	25
26	REPIPE WATER LINES			1999	1,601	41	20	80	39	87	26
27	WINDOWS			1999	81	2	20	4	2	7	27
28	HEAT CONDENSOR			1999	1,203	31	20	60	29	110	28
29	RENOVATION DESIGN			2000	1,950	19	20	41	22	41	29
30	NURSE CALL STATION			2000	3,544	11	20	30	19	30	30
31	DRAPERY			2000	5,588	18	20	47	29	47	31
32	PARKING SPACES			2000	3,720	20	20	47	27	47	32
33	PARKING SPACES			2000	89		20	1	1	1	33
34	WATER HEATER			2000	345	2	20	4	2	4	34
35	GARBAGE DISPOSAL			2000	791	6	20	13	7	13	35
36	TOTAL (lines 4 thru 35)				$ 55,440	$ 1,087		$ 2,152	$ 1,065	$ 4,785	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	RENOVATION DESIGN			2000	2,561	36	20	75	39	75	9
10	RENOVATION PROJECT			2000	398		20				10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,959	$ 36		$ 75	$ 39	$ 75	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1991	UNIT SIX	$	$ 626		$	$ (626)	$	4
5			1991	PEORIA FORR	39,432	595	31.5	595		595	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 39,432	$ 1,221		$ 595	$ (626)	$ 595	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 274,393	$ 14,446	$ 27,439	$ 12,993		$ 212,351	37
38	Current Year Purchases	8,821	931	414	(517)		414	38
39	Fully Depreciated Assets	101,995	46	101	55		101,995	39
40								40
41	TOTALS	$ 385,209	$ 15,423	$ 27,954	$ 12,531		$ 314,760	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,552,307	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 79,864	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 94,607	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 14,743	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 929,065	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SHARON HEALTH CARE ELMS, INC.
0032789
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
SHARON HEALTHCARE ELMS	87,597	14,446	8,759	(5,687)	32,151
PEORIA FOREST	186,188		18,619	18,619	179,987
UNIT SIX					
BARTON MANAGEMENT	608		61	61	213
TOTALS	274,393	14,446	27,439	12,993	212,351
LINE 29: CURRENT YEAR					
SHARON HEALTHCARE ELMS	8,821	931	414	(517)	414
PEORIA FOREST					
UNIT SIX					
BARTON MANAGEMENT					
TOTALS	8,821	931	414	(517)	414
LINE 30: FULLY DEPRECIATED					
SHARON HEALTHCARE ELMS	101,995	46	101	55	101,995
PEORIA FOREST					
UNIT SIX					
BARTON MANAGEMENT					
TOTALS	101,995	46	101	55	101,995
TOTALS (Should Tie to Totals on Page 13)					
SHARON HEALTHCARE ELMS	198,413	15,423	9,274	(6,149)	134,560
PEORIA FOREST	186,188		18,619	18,619	179,987
UNIT SIX					
BARTON MANAGEMENT	608		61	61	213
TOTALS	385,209	15,423	27,954	12,531	314,760

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOCATED-BARTON				6,161			5
6								6
7	TOTAL				$ 6,161 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 11,635 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	VAN	$ 149.00	$ 2,718	17
18					18
19					19
20					20
21	TOTAL		$ 149.00	$ 2,718	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	401	1,048		1,449
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	455	1,189		1,644
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	183	479		662
9	TOTALS	$ 1,039	$ 2,716	$	$ 3,755
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,755			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 5,213

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	18

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						56,540		56,540	13
14	TOTAL			$		$	$ 56,540		$ 56,540	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	56,540
2		
3		
4		
5		
6		
7		
8		
9		
10		
		56,540

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 122,968	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	345,498		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,731		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	184		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 478,381	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	148,545		15
16	Equipment, at Historical Cost	198,413		16
17	Accumulated Depreciation (book methods)	(195,695)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 151,263	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 629,644	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 59,942	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,676		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,666		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,139		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	454,869		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 584,292	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 584,292	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 45,352	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 629,644	$	48

***(See instructions.)**

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
SECURITY DEPOSIT	184	
	184	

OTHER CURRENT LIABILITIES:	Amount	Amount
ACCRUED EXPENSES	18,801	
N/P PEORIA FOREST PTSHP	305,014	
DUE TO SHAREHOLDERS	131,054	
	454,869	

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,313)	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,313)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	50,665	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 50,665	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 45,352	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	SHARON HEALTH CARE ELMS, INC #	0032789	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(5,313)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(5,313)
Equity(Deficit) from Page 17 Col 1		45,352
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		45,352

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,572,291	1
2	Discounts and Allowances for all Levels	(10,669)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,561,622	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,213	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	63,832	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 69,045	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,724	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,724	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,475	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,475	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,638,866	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	697,341	31
32	Health Care	1,028,957	32
33	General Administration	471,024	33
	B. Capital Expense		
34	Ownership	279,986	34
	C. Ancillary Expense		
35	Special Cost Centers	56,541	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,588,201	40
41	**Income before Income Taxes (line 30 minus line 40)****	50,665	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 50,665	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NOT COMPL If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHARON HEALTH CARE ELMS, I # 0032789 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	VENDING COMMISSIONS	1,418
2	PHONE COMMISSIONS	57
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,475

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,200	$ 53,937	$ 24.52	1
2	Assistant Director of Nursing	1,960	2,094	35,814	17.10	2
3	Registered Nurses	17,961	19,630	341,379	17.39	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	28,642	30,303	232,627	7.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,190	4,744	50,493	10.64	8
9	Activity Director					9
10	Activity Assistants	7,472	7,671	59,150	7.71	10
11	Social Service Workers	5,246	5,493	52,528	9.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,915	18,195	161,836	8.89	15
16	Dishwashers					16
17	Maintenance Workers	5,562	5,903	49,921	8.46	17
18	Housekeepers	12,503	13,368	99,276	7.43	18
19	Laundry	6,985	7,571	57,987	7.66	19
20	Administrator	2,080	2,200	41,007	18.64	20
21	Assistant Administrator					21
22	Other Administrative	2,416	2,501	55,916	22.36	22
23	Office Manager					23
24	Clerical	5,367	5,640	89,109	15.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,526	2,782	22,989	8.26	31
32	Other Health Care(specify)					32
33	Other(specify)	99	104	1,644	15.81	33
34	TOTAL (lines 1 - 33)	122,004	130,399	$ 1,405,613 *	$ 10.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	291	$ 10,755	1-3	35
36	Medical Director	104	6,000	9-3	36
37	Medical Records Consultant	22	480	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,200	10-3	39
40	Physical Therapy Consultant	63	2,850	10A-3	40
41	Occupational Therapy Consultant	17	769	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	11	487	10A-3	43
44	Activity Consultant	63	2,220	11-3	44
45	Social Service Consultant	135	4,735	12-3	45
46	Other(specify) PSYCHIATRIC	113	3,960	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	915	$ 33,456		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	447	$ 14,742		50
51	Licensed Practical Nurses	349	9,828		51
52	Nurse Aides	4,665	73,711		52
53	TOTAL (lines 50 - 52)	5,461	$ 98,281		53

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
CNA TRAINER WAGES	99	104	$ 1,644	$ 15.81
	99	104	$ 1,644	$ 15.81

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SEE ATTACHED			$ 96,923
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,923

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALLOC-BARTON	ACCOUNTING/COMPUTE	$ 588
FR&R	ACCOUNTING	7,150
PENSION PERFORMANCE	ACCOUNTING	42
GOLEMBECK REPORTING	LEGAL	387
ALPHA DATA SERVICES	COMPUTER	3,213
CENTRAL PLAZA-THRESHOLD	COMPUTER	1,194
COMPUTER AGE	COMPUTER	707
MID-AMERICA PROGRAM	COMPUTER	1,320
MEDE AMERICAN	COMPUTER	78
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	3,337
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 18,016

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,359
Unemployment Compensation Insurance	8,531
FICA Taxes	105,781
Employee Health Insurance	37,605
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
CHRISTMAS EXPENSE	1,414
EMPLOYEE BENEFITS	1,750
EMPLOYEE RETIREMENT PLAN CONTRIB	620
TOTAL (agree to Schedule V, line 22, col.8)	$ 195,060

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,598
Health Care Worker Background Check	752
(Indicate # of checks performed 107)	
DUES-ICLTC	3,037
ALLOC-BARTON	74
DUES, SUBSCRIPTIONS	391
LICENSES, FEES, PERMITS	455
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,507

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,528
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,528

**See instructions.

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING & DECO	1998	$ 4,594	3	$	$ 1,531	$ 1,531	$ 1,531	$	$	$	$	$
2	PAINTING & DECO	2000	29,580					4,930	9,860	9,860	4,930		
3													
4													
5													
6													
7													
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19													
20	TOTALS		$ 34,174		$	$ 1,531	$ 1,531	$ 6,461	$ 9,860	$ 9,860	$ 4,930	$	$

Facility Name & ID Number SHARON HEALTH CARE ELMS, INC. # 0032789 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **ICLTC - 3037**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **11,446** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **54,351**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit
on Schedule V. $ _____ Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100% if ln 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw